Department of Medical Assistance Services
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http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Providers of Hospice Services and Nursing Facility Services

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 5/18/2015

SUBJECT: Implementation of RUG-Adjusted Rates for Hospice Services Furnished to Nursing Facility Residents — Effective July 1, 2015

The purpose of this memo is to inform you of new billing requirements for hospice providers furnishing services to individuals who reside in nursing facilities. In a Medicaid Memo dated September 26, 2014, DMAS notified nursing facility providers of the change in reimbursement policy to the new price-based payment methodology. At that time hospice providers were not converted to the new billing requirements. Hospice providers were notified via a remittance advice message beginning October 17, 2014 that hospice services would continue to be reimbursed 95 percent of the case-mix adjusted, price-based rates effective July 1, 2014. DMAS will implement Resource Utilization Group (RUG)-adjusted payments under the price-based methodology for hospice services furnished to individuals who reside in nursing facilities for dates of service on or after July 1, 2015.

Claim Billing Information

For claims submitted for dates of service on or after July 1, 2015, there will be billing changes that require hospice providers to submit RUG codes on the claim for individuals who reside in nursing facilities. The direct cost component will be adjusted by the RUG weight on each claim.

Claims will continue to be billed on the UB-04 claim form, the 837I electronic format, or entered through Direct Data Entry by the provider as currently billed. Please adjust billing practices in the following manner:

Revenue and Procedure Codes

Under the new methodology, in addition to billing the revenue codes for routine, continuous care and nursing facility resident services, each hospice claim for an individual who resides in a nursing facility must contain one revenue code "0022" for each distinct billing period of the nursing facility stay. The RUG code determined by the RUG-III, 34 grouper must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment should be reported in the last two digits of the HIPPS rate code. The total charges for revenue code 0022 should be zero. See example of values to be reported.

Revenue Code	HIPPS Rate Code	Units	Billed Charges	Non-Covered Amount
0022	BB201	30	0.00	0.00

Revenue Units
The units reported on the revenue line for 0022 must represent the days covered during the billing period. The revenue code 0658 units for the individual who resides in the nursing facility should equal total units for all revenue code 0022 lines on the claim.

Hospice providers must establish a method to receive the applicable RUG code and type of assessment to complete the HIPPS locator from the nursing facility for each date of service for which the hospice bills.

EDIT Information:

The following edits used in nursing facility price-based payment processing will also be used for hospice services delivered to individuals who reside in nursing facilities:

Edit/ESC	Description
1726	Invalid RUG Group/RUG Group Not Found
1727	Invalid RUG Units
1728	Calculated RUG Amount is Zero

Crossover Claims: Medicare (RUG-IV, Grouper 66)

For Medicare crossover claims, DMAS shall map the Medicare RUG-IV, grouper 66 RUG code submitted on the crossover claim to the Medicaid RUG-III, grouper 34 RUG code. Hospice providers must obtain the Medicare RUG and assessment type for each date of service for which the hospice bills. The map is available on the DMAS website. The Medicaid RUG weight in effect for the date of services will be used to determine the direct operating per diem.

RUG-Adjusted Payment Example

SFY 2015 Transition Claim Per Diem Example – July 1, 2014 to June 30, 2015
The direct rate component of each claim will be calculated based on the RUG weight (case-mix score) during the claim period.

RUG-III, Grouper 34 Group Examples	SE3	CC2	RAB	BB2	IA2
Direct Operating Rate (Case-Mix Neutral)	$83.27	$83.27	$83.27	$83.27	$83.27
RUG-III, Grouper 34 Weight	2.10	1.42	1.24	0.86	0.72
RUG-Adjusted Direct Operating Rate	$174.87	$118.24	$103.25	$71.61	$59.95
Indirect Operating Rate	$ 65.85	$ 65.85	$ 65.85	$ 65.85	$ 65.85
Capital Rate	$13.07	$13.07	$13.07	$13.07	$13.07
NATCEPs Rate	$0.00	$0.00	$0.00	$0.00	$0.00
CRC Rate	$0.01	$0.01	$0.01	$0.01	$0.01
Total Facility Per Diem by RUG Category	$253.80	$197.17	$182.18	$150.54	$138.88
95 Percent of Total Facility Per Diem by RUG Category	***$241.11***	***$187.31***	***$173.07***	***$143.01***	***$131.94***

Total hospice reimbursement shall equal 95 percent of the total facility per diem multiplied by the approved payment days for each billing period.

Rate Posting and Questions

Rates, weights, and Frequently Asked Questions (FAQs) have been posted to the DMAS website at www.dmas.virginia.gov under Provider Services, Rate Setting Information, Nursing Facilities or the rate setting home page at http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx under Nursing Facilities. The RUG-adjusted rates for each nursing facility, and the RUG weights and rates for July 1, 2015

to June 30, 2016 are posted separately and will be posted by June 1, 2015. If you have any questions regarding changes to hospice billing for individuals who reside in nursing facilities you may contact DMAS at the following address NFPayment@dmas.virginia.gov.

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a new program that is coordinating care for thousands of Virginians who have both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx to learn more.

MANAGED CARE ORGANIZATIONS

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.